SUBCOMMITTEE #3:
Health & Human Services

Chair, Senator Mark DeSaulnier

Senator Elaine K. Alquist
Senator Bill Emmerson

March 8, 2012

10:30 AM or
Upon Adjournment of Session

Room 4203
(John L. Burton Hearing Room)

(Michelle Baass)

PLEASE NOTE:

Only those items contained in this agenda will be discussed at this hearing. *Please* see the Senate Daily File for dates and times of subsequent hearings.

Issues will be discussed in the order as noted in the Agenda unless otherwise directed by the Chair.

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VOTE ONLY CALENDAR

8885 Commission on State Mandates

1. SIDS Autopsies

Budget Issue. The Administration proposes to repeal the SIDS Autopsies mandate that requires counties to conduct autopsies on infants who die suddenly and to use state protocols and forms related to Sudden Infant Death Syndrome. The Administration finds that this should be standard operating procedure. This mandate has been suspended since 2003.

Subcommittee Staff Recommendation—Make mandate permissive. Adopt trailer bill language to make this mandate permissive, so that counties may follow the state protocols if they choose to without any reimbursement from the state.

2. SIDS Contacts by Local Health Officers

Budget Issue. The Administration proposes to repeal the mandate that requires local health officers to provide information on counseling and support services to the guardian of an infant who has died from Sudden Infant Death Syndrome. The Administration finds that this should be standard operating procedure. This mandate has been suspended since 2003.

Subcommittee Staff Recommendation— Make mandate permissive. Adopt trailer bill language to make this mandate permissive, so that counties may provide SIDS support services without any reimbursement from the state.

3. Perinatal Services

Budget Issue. The Administration proposes to repeal the mandate that requires local health county practitioners to establish protocols between county health departments, county welfare departments, and all hospitals in the county regarding a substance-exposed infant, and to submit an assessment of needs. The Administration finds that this mandate should be repealed because counties have broad authority to establish protocols for the provision of services to substance-exposed infants. This mandate has been suspended since 2009.

Subcommittee Staff Recommendation—Approve. No issues have been raised with this proposal and it is recommended for approval.

4140 Office of Statewide Health Planning and Development

The Office of Statewide Health Planning and Development (OSHPD) collects and disseminates information about California's healthcare infrastructure, promotes an equitably distributed healthcare workforce, and publishes information about healthcare outcomes. OSHPD also monitors the construction, renovation, and seismic safety of hospitals and skilled nursing facilities and provides loan insurance to facilitate the capital needs of California's not-for-profit healthcare facilities.

Budget Overview. The budget proposes expenditures of $116.5 million ($74,000 General Fund and $1.4 million federal funds) and 473.6 positions for OSHPD.

Workforce Cap Plan. Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, OSHPD was required to reduce its budget by 4 positions and $2.1 million ($17,000 General Fund). This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

1. Song-Brown Health Care Workforce Training Program

Budget Issue. The Governor's Budget proposes a $5 million General Fund reduction to reflect permanent funding for the Song-Brown Primary Care Practitioner Training program from the California Health Data and Planning Fund (CHDPF).

Furthermore, due to CHDPF's significant balance, the Administration is also proposing a reduction in the assessment rate on hospitals and long-term care facilities that support the CHDPF. The annual assessment rate to hospitals and long-term care facilities would be reduced from 0.034 percent to 0.027 percent for hospitals and 0.025 percent for long-term care facilities.

Background. The Song-Brown Program plays a critical role in improving access to health care for California's low-income and uninsured population. There are approximately nine million Californians living in medically underserved areas, with few or no primary healthcare providers. The Song-Brown Program is responsible for increasing the number of family practice physicians, primary care physician's assistants (PA), family nurse practitioners (FNP), and registered nurses (RN) to address access to health care and the critical health workforce shortages.

The Song-Brown Program partners with accredited Family Practice Residency Training Programs and Physician Assistant, Family Nurse Practitioner, and Registered Nurse programs as well as hospitals and other health care delivery systems to increase the number of students and residents training in primary care. By providing financial support via a competitive grant

program to these training and education programs, the Song-Brown Program increases the supply of primary care providers practicing in California's underserved areas.

Prior to 2008-09, the Song-Brown Program was funded 30 percent from the CHDPF and 70 percent from the General Fund. Since 2008-09, the Song-Brown Program has been funded 100 percent from the CHDPF through annual legislative or administrative proposals and the fund is able to permanently support the costs of this program.

Subcommittee Staff Comment and Recommendation—Approve. Funding the Song-Brown Program at 100 percent from the CHDPF saves $5 million General Fund each fiscal year and sustains funding for valuable health workforce education and training programs that provide a critical source of health care services to California's rural and low-income communities.

DEPARTMENTS FOR DISCUSSION

2400 Department of Managed Health Care

I. BACKGROUND

The Department of Managed Health Care (DMHC) was established in 2000, when the licensure and regulation of the managed health care industry was removed from the Department of Corporations and placed in a new, standalone, department.

The mission of DMHC is to regulate, and provide quality-of-care and fiscal oversight for Health Maintenance Organizations (HMOs) and two Preferred Provider Organizations (PPOs). These 125 health care plans provide health insurance coverage to approximately 61 percent of all Californians. DMHC is also responsible for the oversight of 200 Risk Bearing Organizations (RBOs), who deliver or manage a large proportion of the health care services provided to consumers.

Within DMHC, the Office of the Patient Advocate helps educate consumers about their HMO rights and responsibilities.

Assembly Bill 922, Chapter 552, Statutes of 2011 transfers DMHC to the California Health and Human Services Agency (CHHSA) from the Business, Transportation, and Housing Agency effective July 1, 2012. Additionally, AB 922 transfers the Office of Patient Advocate (OPA) to CHHSA effective July 1, 2012 and adds additional duties and responsibilities to OPA effective January 1, 2013. These changes will be discussed at a future subcommittee hearing.

Budget Overview. The budget proposes expenditures of $53 million ($51.1 million from the Managed Care Fund, $755,000 federal funds, and $1.2 million in reimbursements from the Managed Risk Medical Insurance Board and the Department of Health Care Services) and 349.6 positions for DMHC.

Workforce Cap Plan. Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, DMHC was required to reduce its budget by 5 temporary help positions and $1.3 million (Managed Care Fund) by permanently downgrading 16 positions to lower level positions, eliminating temporary help spending, freezing overtime, and reducing Career Executive Assignment position salary. This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

II. ISSUE FOR DISCUSSION

1. Premium Rate Review Cycle II Federal Grant

Budget Issue. The DMHC requests 2 two-year limited-term positions and an increase of federal expenditure authority of $755,000 for 2012-13, $691,000 for 2013-14, and $72,000 for 2014-15 to administer the Health Insurance Premium Rate Review Cycle II Federal Grant.

These positions and spending authority would be used to enhance DMHC's capabilities in collecting premium rate data, improving rate filing requirements, enhancing the rate review process, reporting data to the federal government, and disclosing rate information to consumers.

Background. The Affordable Care Act of 2010 (ACA) makes several fundamental changes to the private health insurance market including a wide variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system. The ACA directs states to establish a formal process for the annual review of health insurance premiums to protect consumers from unreasonable rate increases. To support this, the federal government established grant opportunities that states may apply for to help develop or improve and enhance their current health insurance rate review process.

On September 30, 2010, California passed SB 1163 as conforming legislation to begin aligning California's laws with the ACA. With the passage of ACA and SB 1163, Knox-Keene licensed full-service health plans are now required to file premium rate data for their individual, small employer, and large employer products with DMHC and DMHC is required to review these premium rate filings for unreasonable premium rate increases and issue guidance regarding compliance.

In August 2010, DMHC applied for and received a federal grant (Cycle I) in the amount of $1 million to be shared with the California Department of Insurance. DMHC received $608,000 of this grant. These funds were used to (1) implement the National Association of Insurance Commissioner (NAIC) System for Electronic Rate and Form Filing, (2) enhance DMHC's information technology capacity to support rate review activities, (3) enhance DMCH's website, (4) provide transparency of rate filing information and allow public comments on rate filings, and (5) obtain actuarial services. The Cycle I grant ended December 31, 2011.

In September 2011, DMHC was awarded a Cycle II grant of $2.1 million for October 1, 2011 through September 30, 2014.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

Questions. The Subcommittee has requested DMHC to respond to the following questions.

1. Please provide a brief summary of the proposal.

2. Oversight of Medi-Cal Managed Care Plans

Oversight Issue. A December 2011 report by the Bureau of State Audits (BSA) found that DMHC (1) has inconsistencies in the financial reviews it conducts of Medi-Cal managed care plans run by county entities under the two-plan model (local initiatives), (2) does not have an effective process to monitor local initiatives' response to corrective action plans that result from its financial examinations, and (3) fails to conduct medical audits (intended to review aspects of the provision of health care).

The DMHC concurred with most of the audit findings and recommendations. It is in the process of developing corrective actions, which are expected to be completed by October 31, 2012.

Additionally, recent press articles have outlined severe issues with Medi-Cal Dental Managed Care in Sacramento. The articles highlighted that children may be forced to wait months or even years before receiving needed dental treatment. Some of these concerns focus on DMHC's lack of enforcement to ensure timely access to dental care.

Background. The DMHC is responsible for ensuring that managed health care plans, including local initiatives, are financially viable and comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975. The Knox-Keene Act requires DMHC to conduct a routine medical survey of each licensed full service and specialty health plan at least once every three years. The survey is an evaluation of the plan's compliance with the law in the following areas: quality management, grievances and appeals (member complaints), access and availability, utilization management, and overall plan performance in meeting enrollees' health care needs.

Subcommittee Staff Comment. The DMHC and the Department of Health Care Services share oversight responsibility for Medi-Cal managed care plans. The issues raised by the audit and the recent press articles raise concern as to whether or not the state is prepared to proceed with further Medi-Cal managed care expansions, as proposed in the budget (and to be discussed at a later Subcommittee hearing).

Questions. The Subcommittee has requested DMHC to respond to the following questions:

1. Please discuss DMHC's role in monitoring Medi-Cal Managed Care plans and "specialty" plans such as dental and vision.

2. Please discuss how DMHC shares the information it receives regarding health plan complaints with the Department of Health Care Services and how DMHC follows-up regarding these complaints.

3. Please discuss how DMHC and DHCS coordinate their oversight of Medi-Cal managed care plans and where there are opportunities for improvement.

4260 Department of Health Care Services

1. BACKGROUND

DHCS finances and administers a number of individual health care service delivery programs, including the California Medical Assistance Program (Medi-Cal), California Children's Services program, Child Health and Disability Prevention program and Genetically Handicapped Persons Program. DHCS also helps maintain the financial viability of critical specialized care services, such as burn centers, trauma centers and children's specialty hospitals. In addition, DHCS funding helps hospitals and clinics located in underserved areas and those serving underserved populations.

DHCS programs are designed to (1) deliver health care services to low-income persons and families who meet defined eligibility requirements, (2) emphasize prevention-oriented health care measures that promote health and well-being, (3) ensure access to comprehensive health services through the use of public and private resources, and (4) eEnsure appropriate and effective expenditure of public resources to serve those with the greatest health care needs.

Summary of Funding for the Department of Health Care Services. The budget proposes expenditures of about $61 billion ($15.4 billion General Fund and $33.8 billion in federal funds) for the DHCS and 3,381 positions.

Workforce Cap Plan (WCP). Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, DHCS was required to reduce its budget by $13.4 million. This executive order called for all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

2. ISSUE FOR DISCUSSION

1. Genetically Handicapped Persons Program (GHPP)

Budget Issue. The budget proposes total expenditures of $97.3 million ($63.3 million General Fund, $25.5 million federal funds, $8 million Rebate Fund, $436,000 Enrollment Fees). This reflects technical fiscal adjustments and caseload only.

Background—Genetically Handicapped Persons Program (GHPP). The Genetically Handicapped Persons Program (GHPP) provides comprehensive health care coverage for persons with specified genetic diseases including Cystic Fibrosis, Hemophilia, Sickle Cell Disease, Huntington's Disease, Joseph's Disease, metabolic diseases and others. GHPP also provides access to social support services that may help ameliorate the physical, psychological, and economic problems attendant to genetically handicapping conditions.

Persons eligible for GHPP must reside in California, have a qualifying genetic disease, and be otherwise financially *ineligible* for the CCS Program. GHPP clients with adjusted gross income above 200 percent of poverty pay enrollment fees and treatment costs based on a sliding fee scale for family size and income.

Subcommittee Staff Comment and Recommendation—Hold Open. This estimate assumes that the 10 percent provider payment reductions (as required by AB 97, Chapter 2, Statutes of 2011) would be implemented in February 2012 and would be retroactive to June 1, 2011. These reductions are under court injunction and have not been applied. DHCS indicates that it will update this estimate in the May Revise.

No other issues have been raised regarding this estimate.

Questions. The Subcommittee has requested DHCS to respond to the following questions.

1. Please provide a brief update on GHPP.

2. Child Health and Disability Prevention (CHDP) Program

Budget Issue. The budget proposes total expenditures of $2.4 million ($2.3 million General Fund, and $32,000 Children's Lead Poisoning Prevention Funds). This reflects technical fiscal adjustments and caseload only.

Background: The Child Health & Disability Prevention Program (CHDP).
The CHDP provides pediatric prevention health care services to (1) infants, children and adolescents up to age 19 who have family incomes at or below 200 percent of poverty, and (2) children and adolescents who are eligible for Medi-Cal services up to age 21.

CHDP services play a key role in children's readiness for school. All children entering first grade must have a CHDP health exam certificate or equivalent.

This program serves as a principle provider of vaccinations and facilitates enrollment into more comprehensive health care coverage, when applicable, via the CHDP gateway.

Subcommittee Staff Comment and Recommendation—Hold Open. This estimate assumes that the 10 percent provider payment reductions (as required by AB 97, Chapter 2, Statutes of 2011) would be implemented in February 2012 and would be retroactive to June 1, 2011. These reductions are under court injunction and have not been applied. DHCS indicates that it will update this estimate in the May Revise.

No other issues have been raised regarding this estimate.

Questions. The Subcommittee has requested DHCS to respond to the following questions.

2. Please provide a brief update on CHDP.

3. California Children's Services (CCS) Program

Budget Issue. The DHCS proposes trailer bill language to apply financial eligibility requirements to qualify for the CCS Medical Therapy Program (MTP).

These financial eligibility requirements would be:

- A family income ceiling of $40,000 per year adjusted gross income (AGI) OR
- An estimated annual CCS related medical expenses in excess of 20 percent of family AGI

These financial requirements are the same as those used to qualify a child for CCS diagnosis and treatment services.

The proposal would result in annual savings of $21.9 million ($10.9 million General Fund and $11 million county funds) as 4,779 of 24,433 children receiving CCS MTP would not qualify under the proposed financial eligibility requirements.

Background: CA Children's Services Program (CCS). The CA Children's Services (CCS) Program provides medical diagnosis, case management, treatment and therapy to financially eligible children and young adults, aged 21 years and under, with specific medical conditions, including birth defects, chronic illness, genetic disease and injuries due to accidents or violence. The CCS services must be deemed to be *"medically necessary"* in order for them to be provided.

State law establishes a family income ceiling of $40,000 per year adjusted gross income (AGI) or estimated annual CCS related medical expenses in excess of 20 percent of family AGI in order for a child to be financially eligible for CCS diagnosis and treatment services, but does not require an income standard for the CCS MTP.

The CCS is the oldest managed health care program in the state and the only one focused specifically on children with special health care needs. It depends on a network of specialty physicians, therapists, and hospitals to provide this medical care. By law, CCS services are provided as a separate and distinct medical treatment (i.e., carved-out service).

CCS was included in the State-Local Realignment of 1991 and 1992. As such, counties utilize a portion of their County Realignment Funds for this program.

CCS enrollment consists of children enrolled as: **(1)** CCS-only (not eligible for Medi-Cal or the Healthy Families Program); **(2)** CCS and Medi-Cal eligible; and **(3)** CCS and Healthy Families eligible. Where applicable, the state draws down a federal funding match and off-sets this match against state funds as well as County Realignment Funds.

CCS MTP. The CCS MTP provides physical therapy, occupational therapy, and medical therapy conference services to children who meet specific medical criteria. These services are provided in an outpatient clinic setting known as the Medical Therapy Unit (MTU) that is

located on a public school site. Currently, 24,433 CCS children are served by 125 school based MTUs operated by county CCS programs. Therapists at these sites are employed by the county.

Of these children, 14,273 have an Individual Education Program (IEP) under the provisions of the federal Individuals with Disabilities Education Act (IDEA). Schools are responsible for *educationally* necessary therapy services covered by a child's IEP, and the CCS MTP is responsible for *medically* necessary therapy services covered by a child's IEP.

Summary of CCS Budget Appropriation. The budget proposes total expenditures of $237 million ($68.3 million State Funds, $112.9 million federal Healthy Families Program funds, $49.4 million federal funds from the Safety Net Care Pool, $6.4 million federal Title V Maternal and Child Health Funds) and reflects a decrease of $25.7 million (total funds) as compared to the revised current-year.

As a "county-realignment" program, the DHCS estimates that counties will provide about $111.7 million in County Funds for their share of the CCS Program.

Subcommittee Staff Comment and Recommendation—Hold Open. It is recommended to hold this issue open pending further discussions regarding the interaction between the CCS MTP and school IDEA requirements.

Questions. The Subcommittee has requested the DHCS to respond to the following questions:

1. Please provide a brief overview of CCS MTP.

2. Please provide an overview of this proposal.

4265 Department of Public Health

I. BACKGROUND

The Department of Public Health (DPH) delivers a broad range of public health programs. Some of these programs complement and support the activities of local health agencies in controlling environmental hazards, preventing and controlling disease, and providing health services to populations who have special needs. Others are solely state-operated programs, such as those that license health care facilities.

According to the DPH, their goals include the following:

- ✓ Achieve health equities and eliminate health disparities
- ✓ Eliminate preventable disease, disability, injury, and premature death
- ✓ Promote social and physical environments that support good health for all
- ✓ Prepare for, respond to, and recover from emerging public health threats and emergencies
- ✓ Improve the quality of the workforce and workplace

The department comprises five public health centers, as well as the Health Information and Strategic Planning section, and the Public Health Emergency Preparedness Program. The five public health centers are as follows:

(1) Center for Chronic Disease Prevention and Health Promotion
(2) Center for Environmental Health
(3) Center for Family Health
(4) Center for Health Care Quality
(5) Center for Infectious Disease

Summary of Funding for the Department of Public Health. The budget proposes expenditures of $3.4 billion ($124.8 million General Fund) for the DPH as noted in the Table below and 3,807 positions. Most of the funding for the programs administered by the DPH comes from a variety of federal funds, including grants and subventions for specified areas (such as drinking water, emergency preparedness, and Ryan White CARE Act funds). Many programs are also funded through the collection of fees for specified functions, such as for health facility licensing and certification activities. Several programs are funded through multiple sources, including General Fund support, federal funds, and fee collections.

Of the amount appropriated, about $668.7 million is for state operations and $2.758 billion is for local assistance. The budget for 2012-13 reflects a net decrease of $76.8 million as compared to the revised 2011-12 budget.

Workforce Cap Plan (WCP). Pursuant to Executive Order S-01-10, Control Section 3.90 of the Budget Act of 2010, Budget Letters 10-31 and 10-38, DPH was required to reduce its budget by 171.5 positions and $14.2 million ($2.7 million General Fund) in associated funding for salaries and wages and operating expense and equipment. This executive order called for

all departments to take immediate steps to cap the workforce by achieving an additional 5 percent salary savings by July 1, 2010 and maintain the additional salary savings. The WCP savings were measured by personal services dollars, not personnel years.

Summary of Expenditures for Department of Public Health (dollars in thousands)	**2012-13**
Public Health Emergency Preparedness	**$101,971**
Public and Environmental Health	**$3,125,211**
Chronic Disease Prevention and Health Promotion	283,682
Infectious Disease	579,611
Family Health	1,776,824
Health Information and Strategic Planning	27,279
County Health Services	16,362
Environmental Health	441,453
Licensing and Certification Program	**$200,487**
Licensing and Certification of Facilities	187,288
Laboratory Field Services	13,199
Total Program Expenditures	**$3,427,669**
Funding Sources	
General Fund	$124,805
Federal Funds	$1,998,122
Genetic Disease Testing Fund	$114,885
Licensing and Certification Fund	$87,415
WIC Manufacturer Rebate Fund	$227,000
AIDS Drug Assistance Program Rebate Fund	$246,432
Water Security, Clean Drinking Water, Beach Protection Fund	$102,864
Safe Drinking Water Account of 2006	$56,196
Childhood Lead Poisoning Prevention Fund	$22,428
Radiation Control Fund	$23,218
Food Safety Fund	$7,499
Reimbursements	$244,146
Other Special Funds (numerous)	$172,659
Total Funds	**$3,427,669**

II. VOTE ONLY

1. Childhood Lead Poisoning Prevention Branch – Conversion to State Staff

Budget Issue. The DPH requests to retain 22 positions from the Workforce Cap Plan in lieu of existing contracts of $2.8 million to support the childhood lead poisoning prevention program. The workload includes: the monitoring of 45 state-supported childhood lead prevention programs in local jurisdictions which ensure appropriate care of lead-exposed children; surveillance activities, including providing that at-risk children are screened (blood test) for lead; ensuring universal laboratory reporting of all blood tests to Childhood Lead Poisoning Prevention Branch, so that lead-exposed children are identified; seeing that sources of lead exposure that are found are corrected; and providing administrative support for these functions.

The proposal will save approximately $381,000 (Childhood Lead Poisoning Prevention Fund) annually.

It should be noted that DPH has been phasing-in State civil service positions over a period of time (commencing in 2008-09).

Subcommittee Staff Comment and Recommendation—Approve. This proposal is consistent with state law (Government Code 19130) that prohibits the use of contract staff to perform work that civil service staff can perform. It is recommended for approval. This proposal has no impact on the General Fund.

2. Early Case Capture of Pediatric Cancers

Budget Issue. The DPH seeks $342,000 in federal expenditure authority annually for three years to support grants received by the Centers for Disease Control and Prevention to enhance the California Cancer Registry infrastructure to facilitate more rapid reporting of pediatric cancer cases and to increase availability of these data for surveillance activities at the local, state, and national level.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

3. Reduction of Domestic Violence Training and Education Fund

Budget Issue. The DPH requests a reduction in ongoing spending authority for the Domestic Violence Fund by $280,000 due to a decrease in anticipated revenues. Revenue generated from fines levied against convicted batterers and deposited into the Domestic Violence Fund has declined for a variety of reasons, including a reduction or waiver of fines by local courts, or inability of batterers to pay fines due to poor economic circumstances. No changes to staffing are being requested.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

4. Radiation Safety Program

Budget Issue. The DPH requests to establish as permanent 5 limited-term Health Physicist positions that expire on June 30, 2012; these positions are funded from the Radiation Control Fund ($672,000). This proposal would provide resources for DPH to address the mandated inspected and enforcement activities within the radiation machine and radioactive materials programs and reduce the health risk to the people of California by limiting their exposure to unsafe radiation sources.

Radioactive Machine Inspection Program. Three positions would be located in the Radioactive Machine Inspection Program and would continue to meet existing workload needs. These positions perform X-ray inspections, perform compliance reviews, handle enforcement actions, and investigation of radiologic exposure. According to DPH, this proposal would allow DPH to continue to inspect 900 more X-ray machines annually and investigate 10 additional allegations or medical events.

Radioactive Materials Inspection Program. Two positions would be located in the Radioactive Materials Inspection Program and would continue to meet existing workload. According to DPH, this proposal would allow DPH to continue to perform 80 radioactive materials licensee inspections and 50 investigations and enforcement activities currently being performed by the two limited-term positions.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

5. Environmental Laboratory Accreditation Program

Budget Issue. The DPH requests a decrease in budget authority of $450,000 for the Environmental Laboratory Improvement Fund. The fees from the implementation of the Environmental Laboratory Accreditation Program are deposited into this fund. These accreditation fees have decreased in recent years and the department is requested to align its expenditure authority with revenues.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is recommended for approval.

III. ISSUE FOR DISCUSSION

1. AIDS Drug Assistance Program (ADAP)

ADAP is a subsidy program for low and moderate income persons living with HIV/AIDS who could not otherwise afford them (up to $50,000 annual income). Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the ADAP Pharmacy Benefit Manager (PBM).

There are several issues regarding AIDS Drug Assistance Program funding for 2012-13. These key issues are as follows:

a. Base-line Estimate for ADAP
b. Institution of New Client Cost-Sharing Policy for ADAP for a net reduction of $14.49 million
c. Transition of ADAP Clients to Low Income Health Program

a. Baseline Estimate for ADAP

Comparison of Current-Year & Budget Year. The Office of AIDS (OA) estimates that 39,146 people living with HIV/AIDS will receive drug assistance through ADAP in 2012-13, or a decrease of 2,741 clients over the current year. The budget estimates expenditures of $403.8 million which reflects a *net* decrease of $78 million as compared to the revised current year.

Table: Governor's Estimated Expenditures for Current Year and Budget Year

Fund Source	Revised Current Year	Proposed Budget Year	Difference
General Fund	$5.785 million	$6.445	$660,000
AIDS Drug Rebate Fund	$283.184 million	$245.520 million	-$37.664 million
Federal Funds – Ryan White	$118.797 million	$102.572 million	-$16.225 million
Reimbursements from Medicaid Waiver	$74.064 million	$49.300 million	-$24.393 million
Proposed New Premiums		-$16.486 million	
Total	**$481.830 million**	**$403.837 million**	**-$77.993 million**

Revised Current Year General Fund. OA attempts to minimize the need for General Fund support by maximizing the use of special funds, and federal funds. Consequently, the 2011 Budget Act General Fund expenditures of $82.6 million have been revised to $5.8 million. The *net* decrease of $76.8 million in General Fund is due to:

- A projected decrease based on updated actual expenditure information (as a result of the new Pharmacy Benefit Manager Contract including lower transaction fees, higher split fee savings and lower drug reimbursement rates and ADAP counting towards TrOOP)
- The transition of ADAP clients to the Low Income Health Program
- The receipt of additional federal funds
- An increase in special fund expenditure authority

Discussion of Funding Sources & General Fund Shifts. Historically, three funding sources have supported ADAP: General Fund, the AIDS Drug Rebate Fund, and federal Ryan White CARE Act Funds. Both the AIDS Drug Rebate Fund and federal funds are used as offsets to General Fund support when applicable. As noted below, there is an annual federal maintenance of effort (MOE) requirement for General Fund support.

A new resource available to support ADAP is federal funds available from the state's 1115 Medicaid Waiver administered by the Department of Health Care Services. Federal funds are available through this Waiver since General Fund expended within the ADAP can be counted as "state certified public expenditures" (state CPE) and are used to obtain federal funds through the Waiver financing mechanism. A total of $74 million (Reimbursements from DHCS—federal funds) was identified for current year and $49.3 million for budget year.

Background: ADAP Rebate Fund. Drug rebates constitute a significant part of the annual ADAP budget. This special fund captures all drug rebates associated with ADAP, including *both* mandatory (required by federal Medicaid law) and *voluntary* supplemental rebates (additional rebates negotiated with drug manufacturers through the ADAP Taskforce). *Generally,* for every dollar of ADAP drug expenditure, the program obtains 48 cents in rebates. This 48 percent level is based on an average of rebate collections (both "mandatory" and "supplemental" rebates).

Background: Federal HRSA Maintenance of Effort (MOE) for Ryan White CARE Act. The federal HRSA requires states to provide expenditures of at least one half of the federal HRSA grant award. For example, California's 2011 HRSA grant award is $140 million; therefore, the state match requirement for 2011-12 is $69.3 million. Additionally, HRSA requires grantees to maintain HIV-related expenditures at a level that is not less than the prior fiscal year. California's MOE target, based on 2009-10 expenditures, is $502.5 million.

Background—ADAP is Cost-Beneficial to the State. Without ADAP assistance to obtain HIV/AIDS drugs, individuals would be forced to: (1) postpone treatment until disabled and Medi-Cal eligible, or (2) spend down their assets to qualify, increasing expenditures under Medi-Cal. According to the Administration, 50 percent of Medi-Cal costs are borne by the state,

whereas only 30 percent of ADAP costs are borne by the state. Studies consistently show that early intervention and treatment adherence with HIV/AIDS-related drugs prolongs life, minimizes related consequences of more serious illnesses, reduces more costly treatments, and increases an HIV-infected person's health and productivity.

Subcommittee Staff Comment and Recommendation—Hold Open. Several concerns have been raised regarding the ADAP estimate particularly in regards to the timeline for the transition of ADAP clients to the Low Income Health Program (LIHP) and the estimated savings resulting from this transition. The OA estimates that beginning January 1, 2012, ADAP clients in the first ten counties initiating their LIHPs would begin to transition from ADAP to LIHP. However, Alameda and Los Angeles counties have delayed the implementation of their LIHPs until July 1, 2012. These counties serve potentially two-thirds of the eligible population, and consequently should not be reflected in the current year transition.

The Administration indicates that the ADAP estimate does not account for the updated schedule of LIHP implementation. It will update this estimate in the May Revision.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following questions:

1. Please provide a *brief* description of the *baseline* ADAP budget.

b. Institution of New Client Cost-Sharing Policy for ADAP

Budget Issue. The budget proposes changes to ADAP's cost-sharing by instituting a monthly premium estimated to generate $16.47 million in revenue from ADAP clients. These revenues are offset by $2 million in expenditures for administrative costs associated with the monthly premium.

Therefore, a net reduction of $14.49 million in program expenditures is assumed from this effort. Trailer bill language is required for this action and a July 1, 2012, implementation date is assumed.

The Administration would *significantly* change the existing ADAP client cost-sharing by requiring *all* clients above 100 percent of poverty to pay monthly premiums based upon a percent of gross income. There are four categories of ADAP clients and the cost-sharing reflects differences based on this aspect.

ADAP-Only clients, ADAP-Medi-Cal clients, and Medicare Part D clients would have the *highest* premium payment. For Medicare Part D clients, the cost-sharing obligation excludes clients reaching catastrophic coverage, those dually enrolled in Medicare and Medi-Cal with no Medi-Cal share-of-cost, and all others who qualify for full-subsidy Medicare.

The table below summarizes the share-of-cost assumptions.

Table: Administration's Cost-Sharing Methodology for ADAP Only, ADAP-Medi-Cal, and Medicare Part D Clients

Percent of Federal Poverty Level	Income Range	Share of Cost	Number of Clients Impacted
0-100%	Up to $10,890	None	11,314
101-200%	$10,891 - $21,780	5 percent of gross income	9,736
201-300%	$21,781 - $32,670	7 percent of gross income	7,048
301% to ADAP Maximum	$32,671 - $50,000	10 percent of gross income	4,008

These share-of-costs percentage are the maximum allowable under federal law.

Private Insurance clients would have a *smaller* premium payment of two percent of gross income. The Administration states these clients generate considerable funding for ADAP as the program is able to collect full drug rebate funds on their prescriptions even though the program is only paying a co-pay for their drugs. In addition, some co-pays for this population are already being paid under their other coverage.

Table: Summary of 2012-13 Fiscal Projections

	ADAP	Medi-Cal	Medicare Part D	Private Insurance	Total
Share of Cost Rate	5 / 7 / 10 %	5 / 7 / 10 %	5 / 7 / 10 %	2%	-
Percent of ADAP Clients	54.2% (21,230)	1.3% (505)	24.9% (9,744)	19.6% (7,667)	100% (39,146)
Revenue	$11,667,464	$202,486	$2,151,901	$2,453,113	$16,474,964
Expenditure Savings	$50,209	$23,030	$244,863	$472,668	$790,770
Rebate Loss	-$7,782	$0	-$186,096	-$586,108	-$779,987
Administration	-$1,389,180	-$18,638	-$175,361	-$416,992	-$2,000,171
Total	$10,320,710	$206,878	$2,035,307	$1,922,681	$14,485,577

The OA estimates about $780,000 in Expenditure Savings. This is a result of the estimated 2,692 ADAP clients that will leave the program because the ADAP SOC will exceed their monthly drug costs.

Background: ADAP Eligibility and Current Cost-Sharing. Eligible individuals receive drug therapies through participating local pharmacies under subcontract with the Pharmacy Benefit Manager (PBM). Individuals are eligible for ADAP if they:

- Reside in California;
- Are HIV-infected;
- Are 18 years of age or older;
- Have an adjusted federal income that *does not exceed* $50,000;
- Have a valid prescription from a licensed CA physician; and
- Lack private insurance that covers the medications or do not qualify for no-cost Medi-Cal.

The ADAP is the *payer of last resort*. Individuals who have private health insurance, are eligible for Medi-Cal, or are eligible for Medicare, must access these services *first*, before the ADAP will provide services.

ADAP clients with incomes between $43,561 (401 percent of poverty) and $50,000 are charged monthly co-pays for their drug coverage which is established annually at the time of enrollment or recertification.

The current cost-sharing formula is based on twice the client's individual income tax liability, minus any health insurance premiums paid by the individual. The final amount due can vary greatly depending on the client's tax deductions, that are used to reach their final income tax liability (based on tax return). This amount is then split into 12 equal monthly payments which are collected at the Pharmacy at the time the client picks up their medication

The client's payment is then credited and the amount the Pharmacy bills the ADAP Pharmacy Benefits Manager is adjusted to account for this credit.

LAO Recommendation. The Legislative Analyst's Office (LAO) recommends approval of the Administration's proposal to increase the share of cost borne by ADAP clients due to the state's fiscal situation, not on a policy basis. The LAO also suggests that the Legislature could impose a lower level of cost sharing than the level proposed under the Governor's plan.

Subcommittee Staff Comment. The Administration submitted a similar proposal last year and it was rejected by the Legislature. Under this proposal, the level of cost-sharing is substantially beyond the level of income for individuals enrolled in the program. This could cause some ADAP clients to drop out of the program because they cannot afford to pay the increased costs; and consequently, they would stop taking their medications. Research indicates that increases in drug copayments reduces medication compliance.

The consequences of people going without treatment would be dire. When individuals are unable to obtain appropriate treatment, drug-resistant strains of HIV can develop. Rates of transmissions could subsequently increase because the viral loads of those individuals not receiving treatment would drop. ADAP is the payer of last resort and saves funds in the Medi-Cal Program.

Questions. The Subcommittee has requested the Office of AIDS to respond to the following questions:

1. Please provide a brief description of the proposal and how it would operate.

2. What may the consequences of this approach be?

c. Transition of ADAP Clients to the Low Income Health Program (LIHP)

Oversight Issue. Concerns have been raised that OA's oversight and engagement in the transition of ADAP clients to LIHP has been inadequate. Counties that are implementing LIHPs are struggling with little or no guidance from OA on the LIHP transition. (Currently eight counties have implemented LIHP.) Consequently, clinics and providers serving persons with HIV do not have information to ensure treatment is not interrupted.

For example, LIHP drug formularies may not include anti-retrovirals that were covered under the ADAP formulary. Not all clinics are aware that all medically necessary drugs are required to be provided under LIHP (per federal regulations) even if they are not covered under the LIHP formulary. A lack of guidance and clarity such as this may cause interruptions in drug treatments.

Furthermore, on March 1, the system that is used to enroll individuals into ADAP was updated to include the ability to track ADAP client enrollment in LIHP. Counties were given less than a day's notice regarding these changes and not provided any training or guidance on how to operationalize these changes.

OA has indicated that it will routinely work with the eight counties to identify ADAP clients that have been enrolled in LIHP and required as an interim process for ADAP enrollment workers to notify the ADAP statewide pharmacy benefit manager (Ramsell Public Health Rx) that a client has been enrolled in LIHP, yet it is unable to provide an estimate for the number of ADAP clients that have transitioned to LIHP.

Background. People with HIV living in California have received coordinated medical outpatient care through Ryan White Parts A, B, C, and D, with pharmaceuticals provided largely from ADAP, funded by Ryan White Part B, General Fund, and rebate funds.

LIHP. As part of California's Bridge to Reform section 1115 Medicaid Demonstration, counties are implementing LIHP. The LIHP consists of two programs: Medicaid Coverage Expansion (MCE) and the Health Care Coverage Initiative (HCCI). MCE will provide coverage for very-low income adults with incomes under 133 percent of the FPL and its federal funding through the waiver is capped. HCCI is coverage for low-to-moderate income adults with incomes between 133 and 200 percent of FPL and federal funding for HCCI is capped.

The state projects that 512,000 adults would be eligible for LIHP, with 385,000 eligible for MCE and 127,000 eligible for HCCI. Both programs are at county option and each county determines its own eligibility rules and sets its own income eligibility standards. For example, Los Angeles county set its MCE eligibility level at 133 percent of FPL, whereas San Francisco county set its MCE eligibility level at 25 percent of FPL.

The first ten counties (legacy counties) to implement LIHP are Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura. Los Angeles and Alameda plan to begin enrollment on July 1, 2012.

The OA projects that, under current law, 9,089 ADAP clients are eligible for LIHP in the ten legacy counties. See table below for the estimate by county.

Table: Estimated Number of ADAP Clients Eligible for LIHP in 10 Legacy Counties

Legacy County	Number of ADAP Clients Eligible for LIHP
Alameda	678
Contra Costa	146
Kern	93
Los Angeles	5,152
Orange	700
San Diego	1,321
San Francisco	535
San Mateo	96
Santa Clara	267
Ventura	101
Total	**9,089**

Ryan White – Payer of Last Resort. In the summer of 2011, the federal government provided guidance to California regarding the Ryan White statutory "payer of last resort" requirement in relationship to LIHP. Specifically, that Ryan White funded services, including ADAP, can no longer be available to individuals once they become eligible for and enrolled in a LIHP. Additionally, such low-income persons with HIV who otherwise meet LIHP eligibility standards may not be excluded by the LIHP. This means that low-income persons with HIV previously covered by a Ryan White system of care will, upon enrollment of LIHP, be required to receive their medical care and pharmaceuticals under LIHP.

LIHP Screening Plan. Local health jurisdictions receiving Ryan White Part B funds were required to submit to OA a plan for screening of Ryan White clients for LIHP eligibility by November 15, 2011. According to the plan submission guidelines, these plans were "high-level" plans and not to be more than three to five pages. These plans did not address at the client level issues such as continuity of care, care coordination, and transition of care.

HIV Transition Incentive Program. In order to assure that persons with HIV make their transitions of coverage from Ryan White to LIHP with continuity of quality care, without loss of either core or other critical services, and with minimal disruption to critical patient/provider relationships, the Department of Health Care Services submitted a section 1115 Demonstration amendment to create the HIV Transition Incentive Program. Under the HIV Transition Incentive Program, $150 million would be available annually in 2011-12 and 2012-13 and $75 million in 2013-14 for the development of projects that support the LIHP systems' efforts to address the continuity of care, care coordination, and coverage transition issues for persons with HIV. DHCS expects a response from the federal government on the requested amendment on April 1, 2012.

Subcommittee Staff Comment and Recommendation. In order to ensure the continuity of care and minimal disruption to patient/provider relationships for persons with HIV that are eligible for LIHP, the following actions are recommended:

1. Adopt placeholder trailer bill language that would strengthen consumer protections for ADAP clients as they transition to LIHP and create a stakeholder advisory committee to give expert advice on transition policy decisions. The stakeholder advisory committee would include providers, both medical and non-medical, as well as beneficiaries.

2. Add a Health Program Specialist II position at the Department of Health Care Services to manage the HIV Transition Incentive Program and coordinate with DPH's Office of AIDS. This position would be funded using county funds (via certified public expenditures) and federal funds.

   Substantial work needs to be done in order to effectively manage this new program. It is critical that DHCS have the resources necessary to successfully support and oversee the projects developed under the HIV Transition Incentive Program to ensure that the $375 million is spent in a manner that addresses the continuity of care and care transition for persons with HIV moving into LIHP.

Questions. The Subcommittee has requested the Administration to respond to the following questions:

1. OA, please discuss OA's efforts and guidance to counties regarding the transition of ADAP clients to LIHP.

2. OA, what specific actions has OA taken to avoid interruptions to treatment and prevent barriers to accessing treatment for ADAP clients transitioning to LIHP?

3. DHCS, please provide a brief description and status of the HIV Transition Incentive Program.

2. Drinking Water Program: Three Issues

Background. The DPH has statutory authority to administer California's public Drinking Water Program. The program provides for ongoing surveillance and inspection of public water systems, issues operational permits to the systems, ensures water quality monitoring is conducted and takes enforcement actions when violations occur**.** They oversee the activities of about 8,000 public water systems (including both small and large water systems) that serve more than 36 million Californians.

The DPH is also designated by the federal Environmental Protection Agency (EPA) as the primacy agency responsible for the Administration of the federal Safe Drinking Water Act for California.

California's total need for water system infrastructure improvements is in excess of $39 billion, as reported in the EPA 2007 Drinking Water Infrastructure Needs Survey and Assessment. The majority of public water systems are not able to finance necessary improvements on their own and require state and federal assistance.

a. Safe Drinking Water State Revolving Fund (SDWSRF)

Budget Issue. The DPH requests permanent position and budget authority for the SDWSRF program for 23 limited-term positions that expire on June 30, 2012. Of these positions, 10 have been limited-term since 1999 and 13 were established July 1, 2010, to address increased workload and funding.

The SDWSRF project priority list currently has over 3,000 pre-applications for infrastructure projects from public water systems with a total value of over $8 billion. Since the 13 limited-term positions were established in 2010, the SDWSRF has issued 60 funding agreements annually. Prior to the addition of these staff, about 30 funding commitments were issued annually. By making these staff permanent, DPH proposes to continue issuing 60 funding agreements annually.

Background. Enacted in 1997, under the Safe Drinking Water State Revolving Fund (SDWSRF) program California receives federal funds to finance low-interest loans and grants for public water system infrastructure improvements. DPH has used the SDWSRF to provide loans and grants to 208 public water system projects, executed over $1 billion in funding agreements, and disbursed approximately $727 million. There are currently 44 permanent positions and 23 limited-term positions in the SDWSRF program.

In order to draw down these federal capitalization grants, the state must provide a 20 percent match. The Legislature authorized General Fund appropriations for the 1997 and 1998 capitalization grants, Proposition 13 bond funds for the 1999 through 2002 grants, Proposition 50 bond funds for the 2003 through 2008 grants, and Proposition 84 bond funds for the 2009 through 2011 grants. Assembly Bill 1292, Chapter 518, Statutes of 2011 provides DPH the authority to sell revenue bonds to provide a permanent source of funds for the state match.

The program is comprised of five set-aside funds, as well as a loan fund. The set-asides are as follows:

- Drinking water source protection (15 percent);
- Technical assistance to small water systems (up to 2 percent);
- Water system reliability/capacity development (2 percent);
- State water system program management activities (up to 10 percent);
- Administrative costs (up to 4 percent).

Table: DPH Summary of Safe Drinking Water State Revolving Fund Program

State Fiscal Year	20 Percent State Match	Federal Fund Amount	Total Amount
2011-2012	$13.134 million (Proposition 84) $4.205 million (Revenue Bonds)	$86.698 million	$104.037 million
2012-2013	$17.339 million (Revenue Bonds)	$86.698 million	$104.037 million
2013-2014	$17.339 million (Revenue Bonds)	$86.698 million	$104.037 million
2014-2015	$17.339 million (Revenue Bonds)	$86.698 million	$104.037 million

Subcommittee Staff Comment and Recommendation—Approve. SDWSRF is a mature, long-term program effectively managed by DPH for over 14 years. Congress has continued

funding for this program despite other budget reductions. No issues have been raised regarding this proposal. It is recommended to approve the request.

Questions. The Subcommittee has requested DPH to respond to the following questions.

1. Please provide a brief summary of the Safe Drinking Water Program.

2. Please describe the request to make the limited-term positions permanent.

b. Renewal of Proposition 50 Limited-Term Positions

Budget Issue. The DPH requests the renewal of 12 limited-term positions due to expire on June 30, 2012. These positions support the $485 million in funding allocated to DPH from the Water Security, Clean Drinking Water, Coastal and Beach Protection Act of 2002 (Proposition 50). The DPH requests that these positions be renewed for two more years (through June 30, 2014) to the end of the projected spending plan for Proposition 50.

The positions are primarily engineering classifications, along with related environmental scientist classifications and administrative support. The DPH states these positions are necessary to meet workload needs for key activities as follows:

- Review "pre-applications" for Proposition 50 funding and rank proposals.
- Create a project priority list based on the priority ranking of the projects.
- Evaluate full project applications and prepare extensive technical report documents for each project.
- Review and evaluate the plans and specifications for each project and conduct construction inspections and a final inspection of each project.
- Review proposal for reduction or removal of drinking water contaminants and participate in demonstration projects such as ultraviolet treatment processes.
- Review and comment on draft environmental documents prepared for drinking water projects.
- Conduct final project inspection and certify completion.
- Conduct program fiscal management and administration.

In addition, DPH requests a $1.5 million in state support and $98.9 million in local assistance appropriations from Proposition 50 to align appropriation authority with actual expenditures.

Background. Proposition 50 of 2002 provides funds to a consortium of state agencies and departments to address a wide continuum of water quality issues. The DPH anticipates receiving up to $485 million over the course of this bond measure for water projects. As follows:

Chapter 3—Water Security ($50 million). Proposition 50 provides a total of $50 million for functions pertaining to water security, including the following: (1) monitoring and early warning systems, (2) fencing, (3) protective structures, (4) contamination treatment facilities, (5) emergency interconnections, (6) communications systems, (7) other projects designed to prevent damage to water treatment, distribution, and supply facilities**.**

Chapter 4—Safe Drinking Water ($435 million). Proposition 50 provides $435 million to the DPH for expenditure for grants and loans for infrastructure improvements and related actions to meet safe drinking water standards. A portion of these funds will be used as the state's match to access federal capitalization grants.

With respect to the other projects, the Proposition states that the funds can be used for the following types of projects: **(1)** grants to small community drinking water systems to upgrade monitoring, treatment, or distribution infrastructure; **(2)** grants to finance development and demonstration of new technologies and related facilities for water contaminant removal and treatment; **(3)** grants for community water quality; **(4)** grants for drinking water source protection; **(5)** grants for drinking water source protection; **(6)** grants for treatment facilities necessary to meet disinfectant by-product safe drinking water standards; and **(7)** loans pursuant to the Safe Drinking Water State Revolving Fund (i.e., whereby the state draws down an 80 percent federal match). In addition, it is required that not less than 60 percent of the Chapter 4 funds be available for grants to Southern California water agencies to assist in meeting the state's commitment to reduce Colorado River water use.

Of the $485 million outlined in the bond measure, $353.8 million was made available for commitment to new water projects after accounting for bond costs ($16.975 million), state administration costs ($24.250 million), and the state match for the State Revolving Fund ($90 million).

The department has committed $227.5 million to projects and $126.3 million remains available to be committed. Of the $126.3 million available to be committed, DPH has received project applications for $106.6 million.

Subcommittee Staff Comment and Recommendation--Approve. It is recommended to approve the renewal of the limited-term positions, the increased expenditure authority and related Budget Bill Language. No issues have been raised with this proposal.

Questions. The Subcommittee has requested the DPH to respond to the following questions.

1. Please provide an update regarding Proposition 50 bonds.

2. Please provide a brief summary of the budget request.

3. Please discuss what steps the drinking water program has taken to improve its ability to more quickly fund projects.

c. Small Water System Program

Budget Issue. The DPH requests 2 positions within the Drinking Water Program to carry out small water system regulatory programs in Marin, San Mateo, and Tuolumne counties in response to the decisions of these counties to return primacy to DPH. These positions would be funded from the Safe Drinking Water Account Fund ($183,000). The revenue generated from fees from small public water systems in these counties would support these positions.

These three public water systems have a total of 163 small public water systems that provide potable water to approximately 40,000 persons on a daily basis.

Although small public water systems serve only a small percentage of the state's residents, they represent a disproportionately high risk to public health because they have a greater number of violations and compliance problems than do systems that serve more than 1,000 service connections.

Background. Beginning in 1976, the California drinking water program has been conducted under an agreement with EPA that delegates primacy (i.e., responsibility) to the state. Consequently, DPH is responsible for regulating public water systems in the state. However, Assembly Bill 2995, Chapter 1248, Statutes of 1992, created a process that allowed the state to enter into delegation agreements with local health jurisdictions. These agreements allowed the counties to regulate small public water systems with less than 200 service connections.

Under current law, counties that have been delegated primacy for the regulation of small public water systems can return primacy to the state. The number of counties that were delegated primacy remained relatively stable at approximately 35 for over 15 years. However, since 2007, five counties have returned their small water system programs to the state (Fresno, Tehama, Marin, San Mateo, and Tuolumne).

Subcommittee Staff Comment and Recommendation—Approve. DPH is mandated to establish and maintain a regulatory program for small public water systems. If the state does not adequately fulfill its mandate to protect public health in this area, including those systems that were delegated to the counties, the federal government may withdraw funding. This proposal is consistent with state and federal law. It is recommended for approval.

Questions. The Subcommittee has requested the DPH to respond to the following questions.

1. Please provide a brief summary of the budget request.

2. California Home Visiting Program

Budget Issue. The DPH requests an increase of $20.43 million in federal expenditure authority ($650,000 in state operations and $19.78 million in local assistance) to continue and expand statewide operations of the California Home Visiting Program (CHVP). This program identifies and implements evidence-based home-visiting programs to improve outcomes for low income families who reside in at-risk communities.

This request consists of:

- An increase of $11 million in local assistance funding for the remainder of the Maternal, Infant and Early Childhood Home Visiting Program (MIECHVP) grant funding period through 2014-15. The department received an additional award. DPH finds that this would allow for the continuation of statewide operations of this program and the funding of 13 local health jurisdictions that were selected through a needs assessment process.
- An increase of $9.43 million ($650,000 in state operations and $8.78 million in local assistance) from the competitive Home Visiting Expansion Grant funds. California applied for and received $9.43 million from this competitive grant. DPH will use these funds to expand CHVP to eight additional communities where no home visiting services exist.

Background. The Affordable Care Act of 2010 established a home visiting grant program for states to administer and provided federal grant funds for this purpose. DPH states the initial grant award is available for 27 months and the subsequent grant awards will be available for 24 months. These grant funds cannot be used to supplant any existing funding.

Federal guidelines require services that:

- Promote improvements in maternal and prenatal health, infant health, child health and development;
- Facilitate child development outcomes, school readiness, and the socioeconomic status of eligible families; and
- Reduce child abuse, neglect, and injuries.

Subcommittee Staff Comment and Recommendation--Approve. No issues have been raised regarding this proposal. It is recommended to approve the request. There is no General Fund impact.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. Please provide a brief summary of the budget request, including how the funds will be allocated to the Local Health Jurisdictions.

3. Maternal, Child and Adolescent Health - Reduction in Federal Funds

Budget Issue. The DPH requests to reduce federal expenditure authority by $6.8 million ($2.2 million in state operations and $4.6 million in local assistance) and eliminate 6 positions in the Maternal, Child and Adolescent Health (MCAH) division.

This proposed reduction is a result of several factors, including:

- The redirection of Title V Block Grant funds to programs that were previously funded with General Fund. Since 2007-08, a cumulative total of $13.4 million in Title V funds have been redirected.
- A net reduction in the federal Title V Block Grant funding. On July 15, 2011, DPH received notice from the federal government that the Title V Block Grant would be $800,000 less than the previous year.
- The increased rate of spending by local health jurisdictions (LHJs). In efforts to ensure that local health jurisdictions spent down the local assistance portion of the Title V Block Grant, the department has awarded LHJs contracts that, cumulatively, exceeded the actual federal block grant amount.

MCAH approved appropriations and expenditures have exceeded revenue since 2007-08.

Local Assistance Reductions. DPH convened local MCAH Directors and stakeholders to identify the most equitable and efficacious means to reduce local MCAH spending. This approach ensured that each jurisdiction would continue to fund a MCAH Director to maintain an adequate infrastructure to continue these programs. The reductions to local assistance are:

- $999,000 – Adolescent Family Life Program (AFLP). The AFLP is a statewide program providing case management services to pregnant and parenting teens in California. The number of clients served is approximately 4,200. This reduction will result in 700 fewer clients served. Of this reduction, $749,000 will come from two agencies that planned to discontinue their AFLP programs. The remaining $250,000 in reductions will be prorated among AFLP agencies with base funding above $84,000.

- $140,000 – Black Infant Health (BIH) Program. The BIH programs provides health education, health promotion, social support, and service coordination to pregnant and parenting African American adult women in the 15 LHJs where 75 percent of all African American births in California occur. The program serves nearly 1,700 clients. This reduction will result in a 3 percent reduction in client enrollment.

- $330,000 – Local MCAH Program. Local MCAH programs provide services and programs to improve the health of mothers, infants, children, adolescents, and their families. This reduction will eliminate the Local Assistance for Maternal Health (LAMH) Demonstration Projects. The goal of these projects was to facilitate the LHJ leadership to implement maternal quality care improvement projects. MCAH will continue to provide technical assistance to LHJs who initiate maternity care quality improvement projects through other funding.

- $324,000 – Maternal, Infant Health Information (MIHA) – DPH proposes to charge the cost of the MIHA local assistance survey contract to the Center for Family Health rather than directly to the MCAH program. The MIHA survey benefits all programs of the Center for Family Health and is used to meet multiple federal reporting mandates necessary to receive federal funding.

- $350,000 – California Birth Defects Monitoring Program (CBDMP) – The CBDMP collects and reviews data from birthing hospitals and maintains a database of birth defects occurring in California. This reduction will impact the ability to collect and monitor data for the Birth Defects Registry.

- $1.063 million – California Diabetes and Pregnancy Program (CDAPP) – The CDAPP allocates funding statewide to contractors (CDAPP Sweet Success affiliates) to improve the maternal and fetal birth outcomes through health education and promotion and disease prevention. There are currently over 100 affiliates serving approximately 17,240 clients. This reduction will eliminate affiliate funding.

- $191,000 – Advanced Practice Nurse Training (APN) Program – The APN program provides increased access to cost-effective, quality, reproductive health care services for medically indigent, childbearing women in underserved areas of California by recruiting and enrolling nursing students who reflect the linguistic, cultural, and geographic diversity of California into specialty area programs. Approximately 80 nurses are trained annually, and this 25 percent funding reduction will result in approximately 20 fewer trained nurses.

State Operations Reductions. The reductions to state operations are:

- $1.7 million – MCAH State Operations – Of this reduction, $1.6 million will be from contracts to conduct the Five-Year Needs Assessment and related collection of data at the local level for federal reporting; $65,000 from travel; $20,000 from general expenses; and $81,000 from operating expenses and equipment.

- $500,000 – MCAH Staff Reductions – The department proposes to eliminate 6 positions.

Subcommittee Staff Comment and Recommendation--Approve. A reduction in the federal block grant and the state's fiscal situation require an assessment of MCAH programs and a prioritization of funding for those programs that are the most effective. It is recommended to approve this proposal.

Questions. The Subcommittee has requested the DPH to respond to the following questions:

1. Please provide a brief summary of the budget request.

2. Please comment on DPH's prioritization of MCAH programs and the department's interaction with local MCAH Directors and stakeholders on this prioritization.

4. Women, Infant, Children's Supplemental Food

Budget Issue--Local Assistance Funding. The budget proposes total expenditures of $1.489 billion ($1.262 billion federal funds and $227 million Manufacturer Rebate Funds) for WIC local assistance which reflects an increase of $29.293 million (federal funds) for 2012-13.

DPH states that about 1,5214,110 WIC participants will access food vouchers in 2012-13. An estimated $63.14 is the monthly average participant cost for food.

Of the total federal grant amount, $961.3 million is for Base Food and $300.867 million is for Nutrition Services and Administration. The $227.7 million in Manufacturer Rebate Funds are continuously appropriated and must be expended on food.

Background on WIC Funding. DPH states that California's share of the national federal grant appropriation has remained at about 17 percent over the past 5 years. Federal funds are granted to each state using a formula specified in federal regulation to distribute the following:

- **Food**. Funds for food that reimburses WIC authorized grocers for foods purchased by WIC participants. The USDA requires that 75 percent of the grant must be spent on food. WIC food funds include local Farmer's Market products.
- **Nutrition Services and Administration.** Funds for Nutrition Services and Administration (NSA) Funds that reimburse Local WIC Agencies for direct services provided to WIC families, including intake, eligibility determination, benefit prescription, nutrition, education, breastfeeding support, and referrals to health and social services, as well as support costs.

  States are to manage the grant, provide client services and nutrition education, and promote and support breastfeeding with NSA Funds. Performance targets are to be met or the federal USDA can reduce funds.

- **WIC Manufacturer Rebate Fund.** Federal law requires states to have manufacturer rebate contracts with Infant Formula providers. These rebates are deposited in this special fund and must be expended prior to drawing down Federal WIC food funds.

Background on WIC Program. WIC is 100 percent federal fund supported. It provides supplemental food and nutrition to low-income women (185 percent of poverty or below) who are pregnant and/or breastfeeding, and for children under age five who are at nutritional risk. WIC is not an entitlement program and must operate within the annual grant awarded by the USDA.

WIC participants are issued paper vouchers by Local WIC Agencies to purchase approved foods at authorized stores. Examples of foods are milk, cheese, iron-fortified cereals, juice, eggs, beans/peanut butter, and iron-fortified infant formula.

The goal of WIC is to decrease the risk of poor birth outcomes and improve the health of participants during critical times of growth and development. The amount and type of food WIC provides are designed to meet the participant's enhanced dietary needs for specific nutrients during short but critical periods of physiological development.

WIC participants receive services for an average of two years, during which they receive individual nutrition counseling, breastfeeding support, and referrals to needed health and other social services. From a public health perspective, WIC is widely acknowledged as being cost-effective in decreasing the risk of poor birth outcomes and improving the health of participants during critical times of growth and development.

Subcommittee Staff Comment and Recommendation—Hold Open. DPH has negotiated a new rebate contract effective August 1, 2012. The terms of this contract were not considered as part of this estimate. DPH indicates that it will be revising the WIC estimate to reflect the new rebate contract in the May Revise. It is recommended to hold this item open. No other issues have been raised regarding this estimate.

Questions. The Subcommittee has requested the DPH to respond to the following question:

1. Please provide a brief summary of this request.

5. Genetic Disease Testing Program (Prenatal Program and Newborn Program)

Budget Issue. The DPH proposes total expenditures of $87.8 million (Genetic Disease Testing Fund) for local assistance. This reflects a net decrease of $6.25 (Genetic Disease Testing Fund) as compared to the current-year. This program is fully fee supported.

The proposed expenditures for each of the programs are outlined below.

Program & Components	2012-13	Adjustment Over CY
Prenatal Screening:		
Contract Laboratories	$5,122,000	-$262,000
Technologic Support	13,300,000	-164,000
Systems Development, Equipment & Testing	4,803,000	-1,848,000
Follow-Up Costs	6,242,000	-481,000
Prenatal Diagnostic Services	17,411,000	-174,000
Result Reporting & Fee Collection	1,942,000	0
TOTAL for Prenatal	**$45,820,000**	**-$2,929,000**
Newborn Screening:		
Contract Laboratories	$7,177,000	$29,000
Technologic Support	23,165,000	-2,088,000
Systems Development, Equipment & Testing	3,773,000	-909,000
Case Management	4,575,000	-97,000
Reference Laboratories	2,491,000	-35,000
Diagnostic Services	2,500,000	-221,000
Result Reporting & Fee Collection	1,500,000	0
TOTAL for Newborn	**$45,181,000**	**-$3,321,000**
Total for Genetic Disease Testing Program	**$94,001,000**	**-$6,250,000**

Background—Genetic Disease Testing Program. The Genetic Disease Testing Program consists of two programs—the Prenatal Screening Program and the Newborn Screening Program. Both screening programs provide public education, and laboratory and diagnostic

clinical services through contracts with private vendors meeting state standards. Authorized follow-up services are also provided as part of the fee payment. The programs are self-supporting on fees collected from screening participants through the hospital of birth, third party payers, or private parties using a special fund—Genetic Disease Testing Fund.

The *Prenatal Screening Program* provides screening of pregnant women who *consent* to screening for serious birth defects. The fee paid for this screening is about $150. Most prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

There are three types of screening tests to pregnant women in order to identify individuals who are at increased risk for carrying a fetus with a specific birth defect. All three of these tests use blood specimens, and generally, the type of test used is contingent upon the trimester.

Women who are at high risk based on the screening test results are referred for follow-up services at state-approved "Prenatal Diagnosis Centers". Services offered at these Centers include genetic counseling, ultrasound, and amniocentesis. Participation is voluntary.

The *Newborn Screening Program* provides screening for all newborns in California for genetic and congenital disorders that are preventable or remediable by early intervention. The fee paid for this screening is $113 (which includes the $9.95 fee increase implemented on January 1, 2013 for implementation of AB 395, as discussed below). Where applicable, this fee is paid by prepaid health plans and insurance companies pay the fee. Medi-Cal also pays it for its enrollees.

The Newborn Screening Program screens for over 75 conditions, including certain metabolic disorders, PKU, sickle cell, congenital hypothyroidism, non-sickling hemoglobin disorders, Cystic Fibrosis and many others. Early detection of these conditions can provide for early treatment which mitigates more severe health problems. Informational material is provided to parents, hospitals and other health care entities regarding the program and the relevant conditions and referral information is provided where applicable.

a. Expand California's Newborn Screening Program

Budget Issues. The DPH requests 10 permanent positions and the associated $5.3 million in state operations expenditure authority (from the Genetic Disease Testing Fund) to implement Assembly Bill 395, Chapter 461, Statues of 2011, which requires DPH to add Severe Combined Immunodeficiency (SCID) to the panel of disorders screened for by the Genetic Disease Screening Program Newborn Screening Program. The screening for SCID began on January 1, 2012.

The positions requested are:

- Research Scientist Supervisor I (1) – This position will supervise the new staff and oversee the SCID laboratory.

- Research Scientist IV (1) – This position will review results submitted by the SCID laboratory and evaluates the quality controls.

- Senior Clinical Laboratory Technologist (5) – These positions will be responsible for the daily testing, review, and reporting of SCID laboratory results to ensure that all tests are performed appropriately.

- Senior Laboratory Assistants (3) – These positions will be responsible for the daily, non-technical duties such as laboratory set-up, laboratory equipment operation, process specimens, and assist in quality control efforts.

Background. The Newborn Screening Program screens for more than 75 disorders in over 500,000 newborns and diagnoses more than 700 babies each year. DPH was involved in a pilot study (which ended February 2012) to screen California newborns for SCID, SCID variants, and related T-cell lymphopenias. Over a 12 month period, 18 California newborns have been diagnosed with SCID. Literature and other state's experience reflect an incidence of SCID to be approximately 1 in 100,000 births. Medical treatment is available to eradicate SCID.

It is expected that 256,451 specimens will be processed annually for SCID.

Because the Newborn Screening Program is fully fee supported, a fee increase of $9.95 was implemented on January 1, 2012, to support the ongoing workload associated processing blood specimens and follow-up activities such as diagnostic work-up, confirmatory processing, and provider and family education.

Subcommittee Staff Comment and Recommendation—Approve. No issues have been raised regarding this proposal. It is consistent with state law and is recommended for approval.

6. Federal Special Projects – Position Conversion

Budget Issue. The DPH proposes to convert 348 positions in the temporary help blanket to permanent positions. This proposal seeks to align the approved position authority for DPH with the approved federal and reimbursement expenditures.

Technically, the Administration proposes to redirect 100 existing authorized Workforce Cap Plan (WCP) positions and to request an additional 248 positions. The Administration finds that redirecting the WCP positions for this proposal and the other 2012-13 proposals is more administratively efficient.

This proposal will not impact the General Fund, special funds, or increase the total budget authority for DPH. The only impact will be to increase the number of authorized positions in order to accommodate the federally approved staffing levels.

Background. State personnel policy allows departments to use temporary help blankets. Temporary help blankets are to be used only for payment of employees for a limited duration of time.

DPH has utilized the temporary help blanket for:

- **Federal Special Projects with Personnel** – The department receives a significant number of grants from the federal government. As part of the grant application and award process, the federal government approves the use of state personnel to fulfill the requirements of the grant. Up to this point, the personnel hired to perform these activities have been appointed to the temporary help blanket. These federal projects include:
    - Immunizations – 16 positions - This grant supports efforts to plan, develop, and maintain a public health infrastructure which assures an effective immunization program.
    - Food Emergency Response Network – 5 positions – This grant enhances the state's laboratories to analyze for microbiological, chemical, and radiological threat agents and to improve laboratory capacities for food defense.

- **Reimbursement Activities** – The department has several agreements with other state agencies to provide services. Up to this point, the personnel hired to perform these activities have been appointed to the temporary help blanket. These include:
    - Supplemental Nutrition Assistance Program – Education Program (SNAP-Ed) – 82.5 positions are funded through a reimbursement contract with the Department of Social Services. The SNAP-Ed program provides a wide range of nutrition education services.
    - Safe and Active Communities Branch – 6.0 positions are funded by the Department of Alcohol and Drug Programs and the Office of Traffic Safety. These positions provide epidemiological surveillance, planning, census building,

interventions, policy development, and public information regarding the prevention of injuries.

According to the department, the rational for using the temporary help blanket was primarily due to the nature of the federal funding. Most of the federally funded programs were established as temporary federal projects awarded as grants available from three to five years in duration. Due to the short duration, these grants were treated as special projects and not deemed of sufficient permanence to request regular budgeted positions. Over the past several years, it has been evident that most of the federal special project grants received by DPH are consistent and stable from year-to-year.

Subcommittee Staff Comment and Recommendation—Approve. Moving these personnel into authorized positions will provide the Legislature and the public with accurate and transparent information as to the full staffing level for DPH. Many of these positions have been in existence for over 20 years and should be reflected in the department's permanent personnel count. Consequently, this proposal is recommended for approval.

Questions. The Subcommittee has requested the DPH to respond to the following question:

1. Please provide a brief summary of this request.

7. Loan from Childhood Lead Poisoning Prevention Fund

Budget Issue. The Childhood Lead Poisoning Prevention Fund (CLPPF) has a reserve of $39.5 million, which reflects a 165 percent reserve margin. This reserve level is considerably higher than the 5 percent reserve margin which is normally considered prudent by the Department of Finance (DOF).

The Childhood Lead Poisoning Prevention Fund is funded from fees from companies involved in manufacturing or selling of lead based products or products containing lead. The funds support the Childhood Lead Poisoning Prevention Program.

Subcommittee Staff Comment. Given the substantial reserve of this fund and the state's fiscal situation, a $15 million loan from the CLPPF to the General Fund could be an option for General Fund savings. With a $15 million loan, the CLPPF would still have a reserve margin of 102 percent, well beyond DOF's recommended margin. This loan could be paid back to the CLPPF in 2014-15.

Questions. The Subcommittee has requested the DPH and DOF to respond to the following question:

1. Are there any technical issues with this proposal?